SUMMIT DENTAL, P.C.
Dr. Daniel LePera
5 Summit Ave., Ste. 104
Hackensack, NJ 07601

INSURANCE POLICY

Summit Dental realizes how important insurance benefits are. We ask that you carefully review your policy and/or contact your insurance carrier so you are aware of benefits, frequencies, limitations, and/or restrictions. Our role is to assist you with filing your claims. Please be aware that your insurance may have a yearly allowance (maximum) and anything over that amount will be your responsibility. If you have two insurance policies, please be aware of both policies – not all secondary policies will cover remaining portions. Your insurance mails a copy of an Explanation of Benefits (EOBs) to you. Please pay attention to these statements. Check your policy to see if you have a dental deductible, and if your insurance pays at a percentage of by their allowed fee schedule. Please provide us with a copy of your insurance card and benefit booklet (if available) at your first visit or at the time of dental coverage changes. It is your responsibility to proved us with any future changes in your insurance. If any dental services have been provided with any other provider within the existing benefit year, please advise us.
_____ (Initials) I understand the above information

FINANCIAL POLICY

In order to provide you with the highest quality dental care on a sound business basis, we provide our patients with estimates of fees. Patient, parent and/or guardian are responsible for the patient portion on the date of service. This is not your insurance company's responsibility. We will file all necessary claims to your insurance as a courtesy to you. It is your responsibility to call your insurance company if they have not paid your claim within 45 days from the day of service. Any balance beyond 45 days from the date of service is then your responsibility.
Financial options that we provide at this time:

Cash

Major credit card (American Express - $500.00 and over will be charged an additional 5%)
CareCredit (based on credit approval)

It is your responsibility to complete treatment and follow recommended maintenance schedule. If the treatment and maintenance plans are not followed and/or appointments are missed, adverse results could affect your dental health. If you do not proceed with your treatment plan in a timely manner, further treatment for the involved teeth, supporting tissues, adjacent and opposing teeth, muscles or joints can be affected.

_____(Initials) I understand the above information

APPOINTMENT COMMITMENT

We appreciate you choosing us to meet your dental needs. We take this responsibility seriously and have qualified staff ready to accommodate you during your reserved appointment time.

PLEASE REVIEW THE FOLLOWING:

If circumstances occur and it is necessary to change your scheduled appointment, we request that you give us at least 24 hours notice.

A broken/missed appointment, one in which a patient calls within 5 hours of appt, does not call or show up is not acceptable.

- All broken/missed appointments will be charged for all scheduled services
- All appointments exceeding 1 ½ hours must be secured with a credit card. If cancelled within 24 hours we will charge your credit card for all scheduled services.
- ALL SATURDAY APPOINTMENTS WITH THE HYGIENIST REQUIRES A $75.00 DEPOSIT AND ALL APPOINTMENTS WITH THE DOCTOR REQUIRE A DEPOS OF SCHEDULED SERVICES